DENTAL CREDENTIALING FORM

Please print
Incomplete applications will not be processed

Provider Staff Office Checklist

The following documents are **REQUIRED** for credentialing and consideration for privileges to participate in Kentucky Medicaid.

____ 1. A **COMPLETED** Provider Application that is signed and dated

____ 2. A copy of **CURRENT** valid state license to practice dentistry

____ 3. A copy of **CURRENT** valid anesthesia license (if applicable)

____ 4. A copy of CURRENT valid DEA/CDS registration

____ 5. A copy of CURRENT professional liability insurance policy that indicates carrier name, policy number, expiration date, and policy limits

____ 6. A copy of professional liability claims history (if applicable)

Credentialing is the process of verifying credentials (i.e. training, licensing, hospital affiliations) of potential providers by primary sources. All providers are credentialed following the guidelines of the National Committee fro Quality Assurance (NCQA) to ensure our members that they are receiving the best quality care possible. Using NCQA guidelines for credentialing will ensure an organization that the providers affiliated with their panel are the best in the dental field.

☐ Initial Credentialing ☐ Update/Change

☐ Re-Credentialing

Name of Applicant

Last Name	First Name	Middle Name
Specialty		
Office Contact for Credentialing Information		

Section I
Personal Information

Name (Last, First, Middle)____

Professional Degree (M.D., DDS, DMD):______________________________

Home Address: ____

City/State/Zip: ____

Home Phone: (__)____________________ Years at this Address: _______________

Previous Address if less than five (5) years at current address:____________________

____

Other Names Used:____

Date of Birth (MM/DD/YY): ____________________ UPIN# ________________

Language Spoken: ____

U.S. Citizen? ____Yes ____No If no, status and Visa Number____________________

Social Security # ______________ Federal Employee ID#____________________

Gender: ☐ Male ☐ Female CAQH # ______________________________

Participating Health Plans

Section II
Office Information

Primary Office Address: ____

City/State/Zip: ____

Office Phones: (___)________________(___)__________Fax (___)______________

Office Email: ___________________________Office Manager:__________________

Billing Address:____

City/State/Zip:____

Billing Office Contact Name and Title:______________________________________

Type of Practice (L.L.C., Corp., etc): ______________________________________

Group/Corporate Name: ____

Medicare #:_________________________ Medicaid #___________________________

Federal Tax ID:______________ NPI:_______________ Taxonomy:_______________

EPSDT ☐ Yes ☐ No If yes, EPSDT # ____________________________________

Please list other licensed/certified professional members of your practice:

____

____

____

____

____

____

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Please complete this page if you have additional offices:

Primary Office Address: ____

City/State/Zip: ____

Office Phones: (___) _______________ (___) __________Fax (___)
____

Office Email: ___________________________Office Manager: _________________

Billing Address: ____

City/State/Zip: ____

Type of Practice (L.L.C., Corp., etc): _______________________________________

Group/Corporate Name: ____

Medicare #:________________________ Medicaid #__________________________

Federal Tax ID: ______________ NPI: _______________ Taxonomy:
____

EPSDT ☐ Yes ☐ No   If yes, EPSDT # ___________________________________

If you practice at more than one location, do you require separate checks for each location? ☐ Yes ☐ No

Please list other licensed/certified professional members of your practice:

____
____
____
____
____
____

Office Hours:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Section III
Education

List all, including undergraduate, beginning with the most recent.

School Name:____

Degree Awarded:______________Program Title:_________________________

Mailing Address:____

Dates Attended (MM/YY) From:________ To:________ ADA approved? ☐ Yes ☐ No

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School Name:____

Degree Awarded:______________Program Title:_________________________

Mailing Address:____

Dates Attended (MM/YY) From:________ To:________ ADA approved? ☐ Yes ☐ No

---

School Name:____

Degree Awarded:______________Program Title:_________________________

Mailing Address:____

Dates Attended (MM/YY) From:________ To:________ ADA approved? ☐ Yes ☐ No

---

School Name:____

Degree Awarded:______________Program Title:_________________________

Mailing Address:____

Dates Attended (MM/YY) From:________ To:________ ADA approved? ☐ Yes ☐ No

---

School Name:____

Degree Awarded:______________Program Title:_________________________

Mailing Address:____

Dates Attended (MM/YY) From:________ To:________ ADA approved? ☐ Yes ☐ No

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Section IV
Training

Internships/Residencies/Fellowships/Preceptorships. List all, completed or not, beginning with the most recent.

Institution:____

Mailing Address:____

Dates Attended (MM/YY) From:_______ To:_______ Program Completed ☐ Yes ☐ No

Type of Training/Specialty:____

Program Director:___________________________________ ADA Approved? ☐ Yes ☐ No

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Institution:____

Mailing Address:____

Dates Attended (MM/YY) From:_______ To:_______ Program Completed ☐ Yes ☐ No

Type of Training/Specialty:____

Program Director:___________________________________ ADA Approved? ☐ Yes ☐ No

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Institution:____

Mailing Address:____

Dates Attended (MM/YY) From:_______ To:_______ Program Completed ☐ Yes ☐ No

Type of Training/Specialty:____

Program Director:___________________________________ ADA Approved? ☐ Yes ☐ No

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Licensure Status(Please check all that apply)

☐ General Dental License ☐ Limited Dental License ☐ Teacher's Dental License

☐ Other ____

Are you recognized as a Specialist by the Dental Board? ☐ Yes ☐ No If yes, specify:

Do you hold a permit to administer general anesthesia? ☐ Yes ☐ No
Do you hold a permit to administer conscious sedation? ☐ Yes ☐ No
Do you utilize nitrous oxide in your practice? ☐ Yes ☐ No

Section V
Professional Licensure

List all current Professional Licenses. You must attach copies.

State:______ Type:_________ Number:______________ Issue Date:_____________ Expiration Date:_____________

State:______ Type:_________ Number:______________ Issue Date:_____________ Expiration Date:_____________

State:______ Type:_________ Number:______________ Issue Date:_____________ Expiration Date:_____________

State:______ Type:_________ Number:______________ Issue Date:_____________ Expiration Date:_____________

List all past Professional Licenses:

State:______ Type:_________ Number:______________ Issue Date:_____________ Expiration Date:_____________

State:______ Type:_________ Number:______________ Issue Date:_____________ Expiration Date:_____________

State:______ Type:_________ Number:______________ Issue Date:_____________ Expiration Date:_____________

Section VI
Certifications/Registration

Please attach copies of any of the following certifications if held.

Federal DEA Registration Number: ______________________________________

Date Issued:______________________ Expiration Date: ________________________

State CDS Number: ____________________ State:_____________________________

Date Issued: ______________________ Expiration Date: ________________________

CPR Certified? ☐ Yes ☐ No Expiration Date: ______________________________

If yes, List Classifications: ____

International Graduates: Are you ECFMG Certified? ☐ Yes ☐ No
USMLE/ECFMG Number: ____________________ Issue Date:_________________

Hygienist Licensure: Please list the names of hygienist and licensure held

Name	License #	Expiration Date
______________________	____________________	______________________
______________________	____________________	______________________
______________________	____________________	______________________

Section VII
Specialty Information

Primary Specialty____________________ ☐ Qualified ☐ Certified ☐ Not Applicable

Board Name:________________________Date of Initial Certification: ______________

Does Board Certification Expire? ☐ Yes ☐ No If yes, Expiration Date: _____________

Have you been recertified? ☐ Yes ☐ No ☐ N/A If yes, Recertification Date:_________

If Qualified, when does status expire? ____

If Qualified, date exam scheduled? ____

Board Certification results pending? ☐ Yes ☐ No

Sub-Specialty ______________________ ☐ Qualified ☐ Certified ☐ Not Applicable

Board Name:________________________Date of Initial Certification: ______________

Does Board Certification Expire? ☐ Yes ☐ No If yes, Expiration Date: _____________

Have you been recertified? ☐ Yes ☐ No ☐ N/A If yes, Recertification Date:_________

If Qualified, when does status expire? ____

If Qualified, date exam scheduled? ____

Board Certification results pending? ☐ Yes ☐ No

Section VIII
Work History

List professional work history for the last five (5) years, beginning with the most recent, including academic appointments. Explain any gaps of six months or more.

Practice/Employer: ___________________________
Contact Name: ___________________ Phone: (___)___________
Mailing Address: ___________________________
Dates of Employment: From ___________ To ___________
Reason for Leaving: ___________________________

Practice/Employer: ___________________________
Contact Name: ___________________ Phone: (___)___________
Mailing Address: ___________________________
Dates of Employment: From ___________ To ___________
Reason for Leaving: ___________________________

Practice/Employer: ___________________________
Contact Name: ___________________ Phone: (___)___________
Mailing Address: ___________________________
Dates of Employment: From ___________ To ___________
Reason for Leaving: ___________________________

Practice/Employer: ___________________________
Contact Name: ___________________ Phone: (___)___________
Mailing Address: ___________________________
Dates of Employment: From ___________ To ___________
Reason for Leaving: ___________________________

Please explain work gap history here: ___________________________

Section IX
Professional Liability Insurance Coverage

Please provide information on professional liability insurance for the past five (5) years.

Carrier Name: ____

Carrier Address: ____

Agent Name: ______________________ Policy Number: ______________

Policyholder: ____

Amount of Coverage: ____________________ ____________________
Coverage amount per occurrence Coverage amount per aggregate

Dates of Coverage: From________________ To__________________

Carrier Name: ____

Carrier Address: ____

Agent Name: ______________________ Policy Number: ______________

Policyholder: ____

Amount of Coverage: ____________________ ____________________
Coverage amount per occurrence Coverage amount per aggregate

Dates of Coverage: From________________ To__________________

Section X
Malpractice Claims History

Please provide information for all cases occurring in the past ten (10) years, beginning with the most recent.
☐ None

Date of Occurrence:______________________ Date Claim Filed:___________________
Professional Liability Carrier involved____
You were: ☐ Primary Defendant ☐ Co-Defendant
Describe Allegations against you:____

____

____

Describe alleged injury to the patient: ____

____

Claimant/Plaintiff file suit in Court? ☐ Yes ☐ No If yes, date filed:________________
State Court Case Number:_____________ State:___________ County:______________
Federal Court (U.S. District Court) Case Number:__________ District:_______________
☐Pending ☐Settled ☐Arbitrated ☐Awarded ☐In Appeal ☐Adjudicated
☐Withdrawn ☐Other ____

Date of Occurrence:______________________ Date Claim Filed:___________________
Professional Liability Carrier involved____
You were: ☐ Primary Defendant ☐ Co-Defendant
Describe Allegations against you:____

____

____

Describe alleged injury to the patient: ____

____

Claimant/Plaintiff file suit in Court? ☐ Yes ☐ No If yes, date filed:________________
State Court Case Number:_____________ State:___________ County:______________
Federal Court (U.S. District Court) Case Number:__________ District:_______________
☐Pending ☐Settled ☐Arbitrated ☐Awarded ☐In Appeal ☐Adjudicated
☐Withdrawn ☐Other ____

Section XI
Additional Questions

1. Have any of your board certifications ever been suspended, revoked, or voluntarily surrendered? ☐Yes ☐No

2. Have any of your professional licenses, in any state, ever been limited, sanctioned, voluntarily/involuntarily restricted, denied, revoked, suspended, surrendered, subjected to a consent order, placed on probation or cancelled? ☐Yes ☐No

3. Has your DEA license or state CDS certification ever been voluntarily or involuntarily suspended, restricted, revoked, surrendered, denied, or otherwise limited? ☐Yes ☐No

4. Has a dental license been denied you in any state? ☐Yes ☐No

5. Have you ever been placed on probation or asked to resign from an internship, residency, or other training program? ☐Yes ☐No

6. Have you ever been named a Defendant in any criminal case, other than misdemeanor traffic violations? ☐Yes ☐No

7. Has your malpractice insurance ever been cancelled, suspended, restricted, limited, special rated, or not renewed? ☐Yes ☐No

8. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified (terminated, suspended, restricted, revoked, limited or cancelled)? ☐Yes ☐No

9. Has information pertaining to you ever been reported to the National Practitioner Data Bank? ☐Yes ☐No

10. Have you ever been sanctioned or otherwise disciplined for a violation of ethical standards by a professional organization and/or a licensing board? ☐Yes ☐No

11. Are you engaged in the illegal use of drugs? ☐Yes ☐No

12. Within the last five (5) years, have you been sanctioned, reprimanded or otherwise disciplined in any manner by any state licensing authority or other professional board or peer committee for conduct related to the use of alcohol or the use of drugs? ☐Yes ☐No

13. Have you ever been the subject of a focused review by a peer review organization or similar agency including, but not limited to, Medicare, Medicaid, etc.? ☐Yes ☐No

14. Have you ever received sanctions from a regulatory agency (i.e., CLIA, OSHA, etc.)? ☐Yes ☐No

15. Do you currently have an obligation in a financial aid program administered by Kentucky Higher Education Assistance Authority? ☐Yes ☐No
If so, are you in default of repayment obligation? ☐Yes ☐No

16. Do you, or your business entity, own have an investment in, manage, own Stock in, participate in a joint venture, or act as a partner, contract consultant or medical/dental advisor in any medical/dental enterprise or medical/dental supplier outside of your direct practice where you would financially benefit directly or indirectly? ☐Yes ☐No

If so, please provide the following information:

Name of Organization____
Type of Organization____
Mailing Address ____
Telephone Number ______________________ Tax ID Number______________
Percent of Business Owned/Invested by you__________
Nature of Business Investment_______________________________________
(Owner, partner, investor)

If you answered yes to any of the above questions, please provide an explanation for each affirmative response.

Section XII
Authorization to Release Information

I authorize the Commonwealth of Kentucky and its affiliates, subsidiaries or related entities to consult with administrators, medical staff, malpractice carriers, educational institutions, government agencies, licensing boards, professional organizations, and other persons to obtain and verify information and I release the employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application;

I consent to the release to any person affiliated with the Commonwealth of Kentucky and its contractors or subcontractors all information that may be reasonably relevant to an evaluation of my professional competency, character, and moral and ethical, qualifications, including any information relating to any disciplinary action, suspension or limitation of privileges, and hereby release any such person providing such information from any and all liability for doing so.

This credentialing information and the attached documents contain detailed and specific information relating to my character and professional competence. I warrant that all of the information that I have provided and the responses that I have given are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of this information will be grounds for rejection or termination.

I further agree to notify the Commonwealth of any change to the information provided in this application within thirty (30) days of any such change. I understand that any information provided in this application that is not publicly available will be treated as confidential by the Commonwealth.

WHOEVER KNOWINGLY OR WILLFULLY MAKES, OR CAUSES TO BE MADE, A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT SHALL BE SUBJECT TO PROSECUTION UNDER APPLICABLE FEDERAL OR STATE LAWS. (42USC 1320A-7B, CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS IS PRINTED ON PAGE 11) FAILURE TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED SHALL RESULT IN A DENIAL OF A REQUEST TO PARTICIAPTE IN OR TERMINATION OF THE CURRENT AGREEMENT WITH THE STATE AGENCY, AS REQUIRED BY 42 CFR 455.104 AND KRS CHAPTER 205 AS AMENDED.

Provider Authorized Signature: I certify, under penalty of law, that the information given in this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or for prosecution for Medicaid fraud. I certify that I have read and understand the "Medicaid Rules, Regulation, Policy and 42USC 1320a-7b" (pp. 9-11) to the best of my ability. I agree to abide by the Medicaid Program terms and conditions listed in this document, and I hold a license/certification to provide service corresponding to the information above and for which this agreement applies. I hereby authorize the Cabinet for Health and Family Services, the Kentucky Health Care Partnership to make all necessary verification concerning me and/or my medical practice/facility, and further authorize each educational institute, medical/license board or organization to provide all information that may be needed in connection with my application for participation in the Kentucky Medicaid Program. I also understand that the Dental Credentialing form or CAQH application is considered a continuation of my contract with the KY Department for Medicaid Services. I further certify that, if I keep medical records on an electronic database, those records are confidential and patient privacy is protected (KRS 205.510).

____________________________ ____________________

Applicant Signature Date

____________________________ ____________________

Applicant's Printed Name Phone Number

____

Mailing Address